Is the Chinese Health Bureaucracy Incapable of Leading Healthcare Reforms?: The Case of Fujian Province

Alex HE Jingwei

The competency of the Chinese health bureaucracy has long been questioned in light of past healthcare reform failures. This article, however, by analysing the case of the Fujian Provincial Health Bureau and a policy intervention led by it aimed at curbing rampant cost inflation, demonstrates that with a conducive political environment and firm policy determination, it is possible to achieve effective cost containment without touching fundamental economic levers. The health bureaucracy is not inherently incapable. It still possesses essential authority and policy instruments to exercise strong stewardship. The reassertion of its legitimacy, reinforcement of government stewardship, restoration of the collapsed accountability mechanisms and realignment of government tools epitomise the experiences of Fujian's healthcare reforms.

INTRODUCTION

China has unfolded ambitious national healthcare reforms to overhaul its healthcare system. After years of tinkering, the current reform has finally embarked on a systemic and holistic approach to cure the chronic problems long plaguing this country’s healthcare system. What makes this reform distinct from previous ones is the involvement of virtually all related government agencies. Coordinated by the Senior Vice Premier, a seamless collaboration within the fragmented bureaucracy is expected. Nevertheless, the health administration still needs to play a central role. Unfortunately, the Chinese health bureaucracy has long been criticised as weak, incompetent and protective towards public health facilities. Though the system’s failure to tackle the SARS epidemic and severe deterioration have added much fuel to these charges, the health bureaucracy is not actually the only institution that should be responsible for the sorry state of affairs. Then, given so many weaknesses, is the Chinese health bureaucracy still capable of leading healthcare reforms? Are local health authorities able to take a lead in executing
healthcare reforms in an environment under which Chinese local governments are still largely driven by the pursuit of economic growth? What are the health bureaucracy’s instruments and sources of authority and motivation?

The policy reforms led by the Fujian Provincial Health Bureau are committed to address rampant cost inflation and the notorious problems of *kanbing gui* (medical impoverishment) and *kanbing nan* (expensive accessibility to care). Nowadays, cost inflation occupies the central stage of health policy reforms in most countries. It is a typical “wicked problem” — in the language of policy analysis — where a plethora of interests intertwine and are hard to unravel, making cost containment a rather formidable task. By examining a health policy intervention led by a traditionally weak bureaucracy, this study provides a window for analysing the competency of the Chinese local health administration in carrying out major policy reforms in a difficult policy environment. It demonstrates that the Chinese health bureaucracy is not inherently incapable of leading healthcare reforms. With a conducive political environment and concerted and targeted administrative actions, it is able to largely achieve stated policy goals. At the heart of this reform lies the reassertion of the health bureaucracy’s statutory authority in healthcare regulation coupled with appropriate alignment and innovative development of government tools at its disposal.

**THE CHINESE HEALTH BUREAUCRACY: A HISTORICAL OVERVIEW**

While the direction of China’s healthcare reform has been becoming clearer, there has been a rising recognition of the political dimensions involved. William Hsiao points out that politics can have a greater influence on health policy decisions and their implementation than either economic or health considerations. Politics constrain how much of an optimal economic or health programme can be adopted and implemented.²

The Chinese health bureaucracy, in fact, has been traditionally weak. It was a victim of continuous political struggles under Mao’s reign. The worst time occurred on the eve of the Cultural Revolution when the Ministry of Health (MOH) was charged by Mao as a “ministry for urban lords” (*chengshi laoye bu*), leaving the health bureaucracy a subject of overwhelming condemnation.³ The market transition that started in 1978 did not change the health bureaucracy’s inferior status, as the political standing of a bureaucratic “line” (*tiao*) was increasingly dependent on its

³ David M. Lampton, “The Politics of Public Health in China: 1949–1969”, PhD diss., Stanford University, 1974. Actually, the MOH started to be under huge political pressure not long after the founding of the People’s Republic. Its “conservative” attitude towards Traditional Chinese Medicine (TCM) was drastically criticised by Mao himself who believed that TCM was one of three invaluable contributions that China offered the world.
belonging to the “productive economy” or the “redistributive economy”.4 A health bureaucracy was often mocked as a “toufu agency”. As the central allocation of fiscal resources to healthcare drastically declined in the 1980s, Hsiao argued that the role played by the Chinese MOH deteriorated to technical supervision and moral persuasion, with few policy instruments at its disposal.5 For quite a long period — at least from the 1980s to 1990s — the Chinese government essentially adopted a laissez-faire policy to healthcare while economic growth was the exclusive priority in Beijing’s agenda.

Unfortunately, this situation was exacerbated by the proliferation of government authorities involved in health affairs.6 Huang Yanzhong contends that a policy shift from bandwagoning to buckpassing fundamentally changed the health policy structure in China. As a consequence, a deadlock due to heated opposition or inaction became more likely. The institutional change created a fragmented structure in which the MOH is in a weak position to define policies and exercise stewardship, regulatory and supervisory roles in the health sector.7 Indeed the former Health Minister, Gao Qiang, admitted that health departments at each level lacked organisational and personnel capacities to regulate hospitals.8

The relatively weak power of the Chinese health bureaucracy can be best understood in the historical context of China’s health insurance development. The explosion in healthcare expenditure in the mid-1980s compelled the central government to bring health reform to its policy agenda.9 The task of developing a health insurance reform programme was initially assigned to a group headed by the MOH but its efforts unfortunately failed. The subsequent pilot programmes showed the inability of the health bureaucracy to act as a prudent purchaser or a competent regulator. This led the central government to doubt the ability of the health bureaucracy and hence entrust the Ministry of Labour (MOL) to manage the newly-launched health insurance scheme.

In her PhD dissertation, Lucy Aitchison asserted that in the mid-1990s system at the central government level, the ministries engaged in a fierce battle to control the then-reforming healthcare insurance. At a practical level, they were competing to gain control of the administration of urban health insurance. At a political level, they were negotiating to define the form and content of the health insurance regulations. The ministries were trying to maintain their power in the era of economic reforms, and health insurance was a changing field with new opportunities for control. Aitchison found that the MOL had a clear administrative role that did not depend on income generation. This role could be enhanced by exploiting the increased information available, and developing supervisory control through new laws and regulations. The MOH by contrast, had divided interests. The hospitals, its principal political constituency, were attempting to gain their economic freedom and the MOH seemed reluctant or unable to step back and exercise regulatory and management controls. In the end, the MOH unfortunately lost this competition, leaving its bureaucratic powers further undermined.

Indeed, this protectionism has long made the Chinese health bureaucracy a subject of criticism. One explanation for the poor regulation of health services under the new health insurance scheme was that the MOH and local health departments have protected hospitals. Health departments have traditionally managed health service providers and sympathised with their desire for better salaries, investment in research and development, and high-technology equipment. Where health departments have been placed in charge of local health insurance reforms, they have hesitated to set limits on hospital charges, or to reduce hospital income from sales of medicine.

Aside from this well-known predilection, the Chinese health bureaucracy also suffers from the bureaucratic fragmentation that has been impeding higher-level health authorities from exercising stronger control over local subordinates. Past waves of fiscal reforms have made local governments essential patrons of local health sectors and the so-called dual leadership (shuangchong lingdao) has been disproportionately skewed towards horizontal (territorial) instead of vertical (functional) principals. This explains why some local health authorities failed to protect their public hospitals from being “sold” in many local hospital privatisation cases. All these above-mentioned reasons greatly question the health bureaucracy’s competency.

Yet, recently, several local healthcare reform initiatives suggest that local health bureaucracy could play a more active role in reforms. Notably, as revealed from many anecdotal materials, the health departments in Shenmu County’s universal medical

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insurance scheme and Kunming City’s hospital restructuring demonstrated stronger capacities in policy formulation and execution.13

THE CASE OF FUJIAN PROVINCE: COST INFLATION AND POLICY-MAKING

Fujian is one of the most developed provinces in China. It has experienced constant increases in health spending over the past two decades but this has accompanied GDP growth and the rise of household income. According to the most recent available data, Fujian’s total health expenditure grew by a factor of 6.7 from 1.89 billion yuan in 1991 to 14.49 billion in 2001. Total health expenditure grew slower than GDP in the pre-1999 period, but this scenario ended in 2000. Between 1999 and 2001 alone, total health expenditure increased at 22.8 per cent annually whereas the annual GDP growth was only 9.02 per cent.14 The average bill for inpatient stays in Fujian Province started to rise above that of the national average in 1997. It in fact surpassed rural per capita net income and jumped from 3,402.91 yuan in 2001 to 4,757.53 yuan in 2002 (see Figure 1). All this happened when the general economic inflation level was at a rather low level.

It is widely known that owing to the absence of an effective referral system, the majority of Chinese patients have become accustomed to seeking care directly from high-tiered hospitals, particularly when it comes to catastrophic diseases. If this is factored in, the mounting medical costs become an even heavier burden for the people. In 2001, an inpatient stay in a Fujian hospital would exhaust an average urban resident’s annual income or would impoverish a rural household. The period between 2001 and 2004 saw “an unacceptable cost escalation” perceived by the provincial leaders because the rate of increase in medical costs (11.5 per cent) for the first time outstripped that of the per capita disposable income of urban residents (10.7 per cent), let alone the rural (6 per cent). This was severely aggravated by the high out-of-pocket payment rate (>50 per cent).15

The rapid cost inflation sparked widespread dissatisfaction in Fujian. Compounding this was the gradual disclosure by the media of prevalent unethical behaviour in medical institutions which triggered even more radical criticism.16 The intervention of the provincial people’s political consultative conference and deputies of the provincial people’s congress put heavy pressure on the provincial health bureau.17

15 Ibid.
16 “Ruhe jiejue kanbing gui?” (How to Address the Unaffordability in Healthcare?), Zhongguo yiyao daobao (China Medicine Herald), 9 Aug. 2005.
17 “Luoshi dangpai ti’an, ezhi guodu zhenliao” (Settling Policy Motions from the Democratic Parties and Containing Overcare), Renmin zhengxie bao (News of the People’s Political Consultative Conference), 7 Dec. 2005.
provincial health bureau had in fact been attempting to tackle the problem in the past, but given its inferior bureaucratic standing and weak macro political climate, these attempts were largely constrained whereas the root causes for cost inflation were hardly touched.18

Another factor at that time pushing the health bureau to take action was the poor insurance coverage. Although the New Cooperative Medical Scheme (NCMS) was being gradually rolled out in the rural areas, it was still in the pilot phase in 2004 and the Urban Resident Basic Health Insurance Scheme (URBHIS) was not implemented until 2008. The only social health insurance scheme was the Urban Employee Basic Health Insurance Scheme (UEBHIS) which merely covered about 10 per cent of Fujian’s population till 2004 while more than 80 per cent were not insured at all. This poor insurance coverage meant that soaring healthcare costs were mostly borne by the people. The policy-makers knew that cost containment ought to be carried out primarily by third-party payers, which is the labour authorities in the Chinese context, but given the rather low coverage of the UEBHIS in the pre-reform time, substantive changes

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18 Interview with Dr. Yang, immediate past Director, Fujian Provincial Health Bureau, 12 Sept. 2010.
from the payer side would still yield limited results, not to mention the claim of the labour bureau that reforming the payment scheme would be extremely complex and they were not ready.\textsuperscript{19} Faced with this difficult policy environment, the health bureau believed that it was imperative to take action on its own. In the end, the overwhelming pressure from the political system and the general public in combination with the alarming fact that cost escalation for the first time in Fujian outstripped household income growth made the opening of the policy window possible. Dr. Yang, the immediate past Director of Fujian Provincial Health Bureau describes the initial process:

The costs kept soaring so fast. We (the health administration and public hospitals) became a target of public condemnation. If we were to let them increase at this rate, most people, especially the rural residents would not be able to tolerate it. In the past, we actually did try some measures to curtail the costs but they were only within our Bureau and the hospitals were not cooperative. Year 2004 was a turning point as the increase rate for the first time exceeded household income growth. If no action were taken, this would go to the contrary of the harmonious society. We are the principal government body in charge of health affairs, and thus we could not wait for the problem to get worse.\textsuperscript{20}

While it is indeed crucial to identify the policy problem, this identification itself is merely the first step. Not all public concerns are translated into political issues, given the limited attention and resources of government. The health bureau successfully depicted the situation as adding an unbearable burden to poor households and a potential threat to the building of a harmonious society. The Communist Party announced that “building a socialist harmonious society” was a strategic goal. Despite the persistent centrality of economic development, social welfare issues have been gaining higher positions in the agenda of local governments. Put another way, the overall policy environment in China has been undergoing a paradigm shift from “economic development centred” to “harmonious” development, making the conventional economic rationality no longer able to hold full explanatory power.\textsuperscript{21} This paradigm shift — particularly visible in the Hu-Wen administration — has created a wider space for the advocates of social welfare reforms to manoeuvre for support from political authorities, not to mention the political elites’ paramount concern about social stability.\textsuperscript{22} Liu Yuanli and Rao Keqin argue that the Chinese leaders will find social policies relevant when they are perceived as catalysing social unrest and encumbering economic development.\textsuperscript{23}

\textsuperscript{19} Interview with Mr. Luo, Executive, Fujian Provincial Bureau of Human Resource (Labour) and Social Security, 21 Sept. 2010.
\textsuperscript{20} Interview with Dr. Yang, immediate past Director, Fujian Provincial Health Bureau, 12 Sept. 2010.
\textsuperscript{22} Mr. Chen, Executive, Fujian Provincial Government, 2 June 2010.
The health bureau’s depiction of the severity of the medical cost explosion and potential threat to social stability has caused the provincial leaders to champion its policy initiative to suppress this “unacceptable healthcare cost escalation”.

Compared to a typical policy-making process characterised by lengthy bargaining over budgetary outlays and other resources, the decision-making process has been swift primarily because the potential reform — in the view of provincial leaders — was to be rolled out without additional budgetary allocation. In their studies of China’s health policy process, Liu and Rao conclude that there are two major points in determining the importance of a policy’s relevance: the perceived urgency of a problem by the policy-makers and the feasibility of solving the problem with the given economic and political constraints. This explains the decision-making process behind this healthcare reform in Fujian Province. As resources are limited, the government makes choices according to its political priorities and considers whether there is any policy solution available and a supportive political environment. The perceived solution to rapid cost inflation at that time was the imposition, without additional funds, of tighter regulations on hospital practices through administrative measures.

In order to build consensus among a wider circle of government organs and to legitimise the policy, the Governor decided to place it on the agenda of the subsequent Provincial Government Plenary Meeting, in typical agenda-setting style in China’s provincial policy processes to show the importance of a specific policy issue. The Governor’s decision to bring the cost inflation problem to the first plenary session of 2005 had important symbolic implications as it is the CPC’s tradition to highlight policy issues of critical importance at the first meeting of year. In addition, not only the provincial government line bureaus attend the plenary meeting, but also prefecture and county chiefs. Raising the issue at this meeting would greatly facilitate the consensus-building process within the government system which is essential to effective implementation. The healthcare issues were heatedly discussed at the meeting; and a “conclusion” was reached that the rapid cost escalation was an urgent policy problem that must be addressed through concerted efforts, and that related government organs and local governments were required to cooperate. Successfully winning the endorsement from provincial authorities, the health bureau was greatly empowered to lead the reform.

**POLICY DESIGN**

The fundamental rationale for this policy initiative was underpinned by the belief that the medical sector had been self-serving, there were rampant over-prescriptions, abuse of technology-intensive procedures and there was still room to surrender part of the profits without jeopardising hospitals’ long-term viability. As mentioned above, while curbing cost inflation should depend largely on increased insurance coverage accompanied with appropriate payment methods, it falls in the labour bureaucracy’s jurisdiction

24 Ibid.
where health departments have little say. This was compounded by the fact that the decisions pertaining to reform of the health insurance system, especially experimenting with new payment methods, were to be made by municipal labour bureaus which report directly to municipal leaders because major health insurance schemes are operated at the city level. In fact, the labour bureaucracy declared that it was not ready to initiate the awaited payment experiment due to its well-known complexities.25 Thus, Fujian’s efforts to contain cost escalation were made without touching the insurance system or payment arrangements.26

It is notable that Fujian’s policy-makers mainly targeted large hospitals in this reform endeavour. Compared to lower-level facilities, they apply higher fee schedules, face virtually no constraints in prescribing expensive drugs, and have the luxury to employ state-of-the-art technologies. Therefore, these hospitals with well-qualified staff, advanced equipment and good medical credentials have been key culprits in the cost escalation.

The policy document entitled *Fujian Provincial Health Bureau’s Opinions on Further Containing Healthcare Costs in Medical Institutions* marked the commencement of the reform in 2005.27 It emphasised several times that “health authorities at various levels are responsible for exercising stewardship on public medical institutions”, underscoring its legitimacy as the leader of this initiative. The health bureau also tried to convince hospitals that embarking on this reform would also help them improve service standards, reduce operational costs and restore good reputations.

The central feature of the policy design encompassed five indicators to measure performance of public hospitals in terms of cost control, namely average expense per outpatient visit (AEOV), average expense per inpatient stay (AEIS), appropriate drug utilisation, positive rates of high-tech diagnostic tests and the accuracy rate of service billing. To minimise local discretion and policy distortion, the Fujian Provincial Health Bureau set uniform targets for all medical institutions (see Table 1). AEOV and AEIS are the twin touchstones subject to dynamic monitoring while the other three indicators are measured by spot checks. Explicit targets were set by policy-makers. AEOV and AEIS would see no increase from 2005 to 2006. A “reasonable” increase was to be allowed after 2007 (4 per cent for 2007 and 2008; 3.5 per cent for 2009 and 2010, contingent upon the inflation rate and household income growth rate), but the increase rate was not to go beyond people’s ability-to-bear. This arrangement reflected the provincial leaders’ view that cost increases were allowed to the extent of being “reasonable”. The policy-makers attached an explicit operational definition: an increase in healthcare costs would be considered “reasonable” if they were lower

25 Except Xiamen City which embraced the case-mix payment in a small scale.
26 Interview with Ms. Huang, Managing Director, Healthcare Reform Office, Fujian Provincial Health Bureau, 3 June 2010.
27 *Fujian sheng weisheng ting guanyu jinyibu kaizhan yiliao jigou kongzhi yiliao feiyong zengzhang gongzuode yijian* (*Fujian Provincial Health Bureau’s Opinions on Further Containing Healthcare Cost in Medical Institutions*), 30 Mar. 2005.
than that of urban per capita disposable income. This definition was meant to help avoid misinterpretation and distortion when it comes to implementation at the local level.

A remarkable characteristic of the initial policy design was the absence of “carrots” provided to the hospitals. However, the penalties seemed strict. All five control indicators were brought into the so-called Medical Institution Management Evaluation System. In addition to open reprimands, failing to meet the targets would allegedly affect the careers of hospital administrators. Hospitals were required to link physicians’ cost containment performance with decisions over their promotion and employment. Furthermore, the policy gave specific ceilings for AEIS and AEOV to each hospital. The strictest rule stipulated that hospital income earned beyond the ceilings would be confiscated by health authorities and re-allocated to other purposes including medical education, public health and rural healthcare.\(^{28}\)

**SOURCE OF POWER AND THE BUREAUCRACY-CONSTITUENCY RELATIONSHIP**

Despite their weak bureaucratic power, the health authorities still lead the public health system. The provincial health bureau, for instance, is still in charge of “implementing the guidelines of medical institution reform stipulated by the MOH, supervising and administering medical institutions according to related laws, and supervising the enforcement of medical professional standards, medical quality standards, and service quality”.\(^{29}\) This is the principal source of its statutory authority. Moreover, each level of the health authorities owns its own health facilities, ranging from public hospitals and centres of disease control (CDCs), to specialised medical institutions, blood centres and so forth. Although past waves of hospital decentralisation reforms have granted a great deal of autonomy to health facilities such as residual claimant rights, equipment

\(\text{\(^{28}\) Ibid.}\)

\(\text{\(^{29}\) Fujian sheng weisheng ting zhuyao zhize (Main Functions and Responsibilities of Fujian Provincial Health Bureau), 10 Apr. 2008.}\)
acquisition and decision rights on bonuses, as well as staffing and management, health authorities still maintain their control in major ways, including appointment of hospital managers, enforcement of clinical standards, administration of hospital gradation and maintenance of medical codes of conduct.\textsuperscript{30}

The strong endorsement from the provincial government also greatly empowered the provincial health bureau to pursue its policy agenda. The Bureau in essence exercises the ownership of provincial public hospitals, which empowers it to require obedience. It also conducts regular inspections to check provincial hospitals’ cost containment work. Fujian’s policy initiative was highly encouraged by the MOH which was keenly expecting the emergence of local initiatives to combat cost inflation. Over the years, it consecutively invited the Fujian Provincial Health Bureau to deliver keynote speeches outlining its experience to senior health officials from all over China at the annual National Health Administrator Conference, a highly-regarded privilege in Chinese politics, signalling recognition and endorsement from the Center and further reinforcing the policy’s legitimacy.

The guiding principle of Fujian’s cost-containment initiative was the belief that the medical sector had earned more than reasonable profits by providing unnecessary care. It thus ordered hospitals to render part of the profits to mitigate the expensive accessibility as not only morally imperative but also justifiable. If it were not for government ownership of public hospitals, this type of policy intervention would be nearly impossible. From the very beginning, top leaders in the province and the actual policy-makers in the health bureau believed that compressing hospitals’ profit margins to a \textit{moderate extent} would not jeopardise their viability. Indeed, the provincial health bureau was actually a strong supporter of this course of action. Yet, does this contradict the widely-held notion that the Chinese health bureaucracy is reluctant and unable to exercise \textit{bona fide} control over health facilities due to its natural kinship with the medical profession and its weak bureaucratic power?\textsuperscript{31}

Grindle and Thomas found four concerns integral to decision-makers’ choice on policy reform in developing countries, including power, budget, prestige and clientele/constituency.\textsuperscript{32} Arguably, the Chinese health bureaucracy has been a major loser in the marketisation reform. The deterioration of budgetary muscle has remarkably undermined its power, which was further weakened by the cutting of personnel in the massive government organisational reform that took place under Zhu Rongji’s administration. An even worse situation was in 2003 when the Minister of Health was the first Cabinet Minister to be dismissed in the Hu-Wen administration. This brought about catastrophic damage to the health bureaucracy’s prestige, let alone the release

\textsuperscript{30} When it comes to the appointments of managers at large, important hospitals, the CPC Organisation Departments administer them at various levels.


of the Development Research Centre’s (State Council) famous report concluding that “China’s healthcare reforms have been basically unsuccessful”. 33

Although it correctly reveals the underlying bureaucracy-constituency relationship between the Chinese health bureaucracy and health facilities, it neglects the basic fact that the health bureaucracy’s political standing has been at stake owing to poor performance of the healthcare system and vast public dissatisfaction. It is widely accepted that the woes of China’s healthcare have been a result of various system failures, and the health bureaucracy has unfortunately been the natural and immediate institution subject to enormous reproachments. Trapped in this dilemma, the health bureaucracy was primarily driven by the motive to defend its bureaucratic interests by aligning itself with the public, and thus chose to exercise much more rigid stewardship on its constituencies.

To make informed policy decisions, the health bureau needed to know the financial situation and profit-margin of the public hospitals, but this information was not available. It then commissioned an investigation team to find out how many dollars could be saved from providers’ unnecessary services. This team examined thousands of medical records from recent years, and it was found that 20 per cent of the expenses incurred — including service fees and drug prescriptions — were not justifiable and could be essentially seen as medically unnecessary. 34 The policy-makers clearly knew the importance of cooperation from hospitals. Thus, the health bureau organised a series of meetings with hospital managers making moral appeals and seeking cooperation. As expected, these old-style moral persuasions were limited in effect. The health bureau then used the investigation results as a weapon to counter hospitals’ resistance. In the end, the provincial hospital managers basically accepted the terms and conditions after several meetings. Municipal health departments were later asked by the provincial bureau to summon the hospital managers under their jurisdictions to do the same tongyi sixiang (seeking for consensus), a salient characteristic of the Chinese public policy process. Underlying it is the health bureaucracy’s legitimate role as the functional supervisor of the health sector.

Preliminary Assessment and Progressive Reform

The policy outcomes were fairly encouraging in the first two years. The AEOV control targets were largely achieved, and five hospitals even managed to reduce their average costs by more than 10 per cent. The performance in containing inpatient costs was generally good, though a few large hospitals still broke the cap. Overall, the committed zero increase was realised for these twin indicators. 2006 saw more impressive progress. Except for a very few cases, most hospitals experienced further decreases in both AEOV and AEIS. By the end of that year, 94 per cent of the public health

34 Interview with Dr. Yang, immediate past Director, Fujian Provincial Health Bureau, 12 Sept. 2010.
facilities had achieved the control target for AEOV, while 92 per cent managed to do so for AEIS. 160 facilities reached the targets for both, accounting for 88 per cent of the total. Progress was also gained in the other three control indicators. The positive rates of high-tech diagnostic tests was 81.5 per cent in 2006, better than the target (70 per cent) and the target for accuracy in service billing was also achieved. However, following spot checks, only 84.1 per cent of the drug prescriptions were considered clinically appropriate in 2006, whereas the target was 95 per cent,\(^{35}\) and the rate was even poorer in the previous year, suggesting the resilience of over-prescription to administrative measures.

Inappropriate drug use has been a major problem for the Chinese health policymakers. As a result of dwindling government subsidies and the defective pricing system, Chinese hospitals need to generate more than half of their income from drug sales.\(^{36}\) Interestingly, drug income as a percentage of hospital income dropped from 55 per cent to less than 50 per cent while no external restrictions were imposed in Fujian’s first-tier hospitals, implying that hospitals had to curtail unnecessary drug use in order to meet cost control targets. However, feedback from hospitals and municipal health departments indicated that squeezing the profit margin without increasing government subsidies put hospitals in a difficult situation and they were forced to further increase the already heavy workload. This in turn sparked staff complaints and staff morale was damaged.\(^{37}\)

To account for the possibility that Fujian’s decline in healthcare costs actually reflected a common trend across localities, its cost profiles were compared with those of the national average and a group of comparable provinces at the first-tier hospital level because they were the primary subject of Fujian’s cost containment reform. In selecting the comparison group, overall economic status proxied by GDP per capita, health system’s physical capacity measured by the number of hospital beds per 1,000 people, personnel capacity measured by the number of health professionals per 1,000 people, as well as healthcare costs indicated by AEOV and AEIS, were taken into consideration. In the end, Jiangsu Province and Guangdong Province were selected. Together with Fujian, Jiangsu and Guangdong enjoy membership in China’s eastern “rich club” and are similar in socioeconomic development.

Figures 2 and 3 contrast outpatient cost profiles in first-tier provincial and municipal public hospitals in Fujian, Guangdong and Jiangsu with the national average (Jiangsu and Guangdong’s data were from 2003 to 2009, and Guangdong’s data for municipal hospitals were unavailable). The national average for provincial first-tier hospitals nearly doubled


\(^{37}\) Interview with Dr. H at Fujian M Hospital on 4 June 2010; interview with Dr. Z at Fuzhou S Hospital on 26 Sept. 2011; interview with Dr. L at Xiamen Z Hospital on 17 May 2010.
Figure 2. Average outpatient costs in 1st-tier provincial public hospitals of Fujian, Guangdong, Jiangsu and the national average, 1999–2009

Unit: yuan

Figure 3. Average outpatient costs in 1st-tier municipal public hospitals of Fujian, Jiangsu and the national average, 1999–2009

Unit: yuan

Source: Data before 2003 were compiled from Quanguo weisheng tongji nianbao ziliao (National Health Statistics Reports) (Beijing: Ministry of Health, PRC, various years). National data after 2003 were from China Health Statistics Yearbook (Beijing: China Union Medical University Press, various years). Fujian’s data after 2003 were obtained courtesy of Ms. Wang Weiqin and Ms. Xiao Yuqing, Office of Planning & Finance, Fujian Provincial Health Bureau, collected on 27 Sept. 2010. Jiangsu’s data come from Health Service Statistics Bulletin of Jiangsu Province, 2004–2010. Guangdong’s data are from the Guangdong Provincial and MoH-affiliated Hospital Medical Information Disclosure System [10 Oct. 2010].
from 122.74 yuan in 1999 to 240 yuan in 2009. Meanwhile, the outpatient costs in Guangdong and Jiangsu — two other “rich-club” members — also underwent remarkably faster increases compared to those in Fujian. After five years’ rapid increase, the trend in Fujian became markedly smoother, and it stabilised following the policy intervention. AEOV increased by less than 2 yuan between 2005 and 2007. The same situation also occurred in municipal hospitals; Jiangsu and the national average exhibited nearly identical patterns of rapid cost increases while the average costs in Fujian’s municipal hospitals increased much more slowly after 2005 when the policy initiative began.

Figures 4 and 5 compare the profiles of inpatient costs. The inpatient costs in Fujian’s provincial hospitals saw a steep increase of 37 per cent during the pre-reform period. Meanwhile, the national figure also rose rapidly. Following the policy intervention, Fujian’s provincial hospital average inpatient bill quickly fell from 11,274.46 yuan in 2004 to 10,683.60 yuan in 2006, at a rate of 5.24 per cent. In the meantime — in stark contrast — the average inpatient bill among all Chinese provincial hospitals increased from 8,925.40 yuan to 9,686.00 yuan while affluent Guangdong and Jiangsu led an even faster trend in cost escalation at their provincial hospitals. This pattern also holds true in the municipal category.

Admittedly, a large proportion of public hospitals in Fujian have failed to hold the mandated ceiling (4 per cent for 2007 and 2008, and 3.5 per cent for 2009) for cost increases since 2007 when the so-called “reasonable increase” began. But when compared with Guangdong, Jiangsu and the national average, cost increases for both inpatient and outpatient care in Fujian’s public hospitals have been far slower (see Table 2).
Figure 5. Average inpatient costs in 1st-tier provincial public hospitals of Fujian, Guangdong, Jiangsu and the national average, 1999–2009

Unit: yuan

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Source: Data before 2003 were compiled from Quanguo weisheng tongji nianbao ziliao (National Health Statistics Reports) (Beijing: Ministry of Health, various years). National data after 2003 were from China Health Statistics Yearbook (Beijing: China Union Medical University Press, various years). Fujian’s data after 2003 were obtained courtesy of Ms. Wang Weiqin and Ms. Xiao Yuqing, Office of Planning & Finance, Fujian Provincial Health Bureau, collected on 27 Sept. 2010.

Table 2

Average cost increase rates (%) in provincial and municipal public hospitals in Fujian Province and national average level, 1999–2009

<table>
<thead>
<tr>
<th>Year</th>
<th>Provincial Hospital</th>
<th>Municipal Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>6.93</td>
<td>7.40</td>
</tr>
<tr>
<td>2008</td>
<td>6.16</td>
<td>7.01</td>
</tr>
<tr>
<td>2007</td>
<td>5.42</td>
<td>6.86</td>
</tr>
<tr>
<td>2006</td>
<td>4.75</td>
<td>6.37</td>
</tr>
<tr>
<td>2005</td>
<td>4.09</td>
<td>5.97</td>
</tr>
<tr>
<td>2004</td>
<td>3.45</td>
<td>5.50</td>
</tr>
<tr>
<td>2003</td>
<td>2.83</td>
<td>5.07</td>
</tr>
<tr>
<td>2002</td>
<td>2.19</td>
<td>4.50</td>
</tr>
<tr>
<td>2001</td>
<td>1.57</td>
<td>4.00</td>
</tr>
<tr>
<td>2000</td>
<td>0.95</td>
<td>3.50</td>
</tr>
<tr>
<td>2009</td>
<td>0.37</td>
<td>3.00</td>
</tr>
</tbody>
</table>

Source: Data before 2003 were compiled from Quanguo weisheng tongji nianbao ziliao (National Health Statistics Reports) (Beijing: Ministry of Health, various years). National data after 2003 were from China Health Statistics Yearbook (Beijing: China Union Medical University Press, various years). Fujian’s data after 2003 were obtained courtesy of Ms. Wang Weiqin and Ms. Xiao Yuqing, Office of Planning & Finance, Fujian Provincial Health Bureau, collected on 27 Sept. 2010.
Encouraged by these impressive outcomes, some important policy developments were translated from proposals into reality, the most significant of which was the incorporation of cost containment-related indicators into the performance evaluation system of municipal governments and cadres.\textsuperscript{38} In fact, the policy-makers found a lack of motivation among municipal governments to support this policy initiative and this considerably affected the momentum of municipal health departments. In order to further motivate municipal governments to engage in the reform, the provincial government decided to incorporate cost containment indicators into the revised performance evaluation system, signalling stronger support.\textsuperscript{39}

As a matter of fact, in spite of Fujian’s relative affluence, public hospitals on average received only 6 per cent of their income from government subsidies, similar to the national picture. Although the provincial health bureau had long been expecting more funds to be given to the hospital sector, unfortunately, the message from the finance authorities was still disappointing. Recognising the absence of tangible monetary incentives to hospitals in the initial policy design, and the continuous complaints about squeezed profits, the health bureau decided to change the way in which it subsidises public hospitals. Departing from traditional block funding, public hospitals from 2010 started to receive part of their subsidies based on the results of cost containment work. Admittedly, the financial incentives given to hospitals are still weak as government subsidies still account for a trivial proportion, but with the increasing budgetary injections committed by the national healthcare reform, this new subsidy scheme will become a vital lever.

**IMPLICATIONS FOR THE ONGOING NATIONAL HEALTHCARE REFORM**

China’s past rounds of healthcare reforms proved failures.\textsuperscript{40} Among others, one important reason was the failure to exercise government stewardship. Hospitals essentially run themselves like for-profit entities. A widely-held fallacy assumes that since the government could not finance the medical sector adequately, granting them great autonomy and turning a blind eye to their occasional misbehaviour were justifiable. Unfortunately, past experience provided ample evidence of the scale at which the greatly weakened accountability mechanism could lead to numerous leaks in the regulatory system. Profit-driven healthcare providers could easily extract unreasonable fees by inducing demand despite unaffordability and medical impoverishment. While large autonomy

\textsuperscript{38} Fujian sheng difang dangzheng lingdao banzi he lingdao ganbu kaohe pingjia banfa (Local Government and Cadre Evaluation Methods of Fujian Province), 2010; Fujian sheng weisheng ting guanyu kaizhan 2010 nian tongzhi yiliao feiyong youguan gongzuo de tongzhi (Fujian Provincial Health Bureau’s Notice on Cost Containment Work in 2010), 26 Apr. 2010.

\textsuperscript{39} Interview with Mr. Chen, Executive, Fujian Provincial Government, 2 June 2010.

is granted to hospitals, and they are exposed to market pressures, the accountability mechanisms must be reinforced and government stewardship must be actively exercised.

As argued by Wu and Ramesh, a potential problem with hospital autonomy is that it weakens the ability of mechanisms to enforce accountability over public hospitals. The gradual erosion of traditional accountability mechanisms based on hierarchy and civil service rules weakens the capacity of governments to monitor performance and require improvements.\textsuperscript{41} Therefore, an optimal mix of autonomy and control must be put in place to ensure that autonomy is not abused in pursuit of profits, and that governments can still hold hospitals accountable.\textsuperscript{42} The case of Fujian has shown that the government’s inability to fully subsidise public hospitals does not constitute a justification for various unethical behaviours prevalent in the healthcare system, and the health bureaucracy could still stand up as the legitimate enforcer of various regulations and supervisor of public medical institutions. Of course, this must be built on a conducive political environment, and in particular, firm support from the government.

However, this particular type of policy intervention suffers from its own limitations. First, while policy-makers set strict targets for average medical costs, there is no volume control. Second, the administration does not have essential information on hospitals’ real profit-margins and the magnitude of induced demand. Thus, the setting of cost ceilings is not free from arbitrariness. Third, the health administration does not regulate the mix of drugs, diagnosis and treatment, which could be manipulated by hospital managers. These inherent limitations open the door for hospitals’ various opportunistic behaviours that distort the original policy intention and cause a variety of undesired consequences.

Arguably, political support is a vital precondition for Fujian’s reform. However, this support mirrors the political leaders’ anxious search for recipes that could bring immediate relief to pressing policy issues to safeguard “social stability”. Real-world policy-makers are often shortsighted. In electoral democracies, it is the pressure on politicians to get re-elected that pushes them to satisfy voters. In China’s authoritarian system, policy-makers are also apt to make shortsighted decisions in the interests of their careers. To a large extent, Fujian’s reform can be regarded as a campaign for “instant solutions”. However, their sustainability is open to question.

This reform model will be adopted by other provinces soon. Although an ambitious national healthcare reform has been carried out for nearly three years, Dr. Chen Zhu, China’s Health Minister, admitted that the rapid cost inflation is barely mitigated and healthcare is still a heavy financial burden to most Chinese citizens.\textsuperscript{43} While hoping that the systemic reform would address the root causes, the MOH finally realised

\begin{itemize}
\item \textsuperscript{41} Wu Xun and M. Ramesh, “Health Care Reforms in Developing Asia: Propositions and Realities”, \textit{Development and Change} 40, no. 3 (2009): 538.
\item \textsuperscript{43} See “Weisheng bu jiang kaoping yiyuan kongzhi yiyao feiyong qingkuang” (MOH to Evaluate Hospitals’ Performance in Cost Containment), \textit{Xin Jing Bao (New Beijing News)}, 7 Jan. 2011.
\end{itemize}
that it is imperative to take immediate administrative action. The National Health Work Conference held in January 2011 announced that the MOH would put cost containment at the top on its agenda and lead the entire health bureaucracy in this battle. It stressed the crucial role of administrative measures in cost containment, and asked local health authorities to exert tight regulation by setting “scientific control targets” on cost indicators at public hospitals, especially average inpatient and outpatient bills. The MOH emphasised that utilising a combination of administrative, economic and legal means is imperative. This is the first time the Chinese health policy-makers declared that concerted administrative actions will be taken within the entire medical system to deal with cost inflation.

This recent development reflects policy-makers' frustration with the resilience of cost inflation to a variety of reform measures, giving rise to the decision to return to traditional “command-and-control” tools to contain medical costs. This upcoming nationwide cost containment campaign greatly resembles Fujian’s policy intervention, in terms of guiding principles, tools and targets. Until 2011, Fujian had been the only province to use administrative intervention to address healthcare cost inflation. The efficacy and limitation of this type of policy intervention is best analysed from Fujian’s case, and merits further investigation.

CONCLUDING REMARKS

This article examines the healthcare reform initiative led by the Fujian Provincial Health Bureau aimed at curbing cost escalation. It demonstrates that the Chinese local health bureaucracy is not inherently incapable as widely accused. The failure of past waves of healthcare reforms should be attributed largely to weak governmental stewardship and under-articulated legitimacy of the health bureaucracy in regulating the health sector. With strong government endorsement, the Fujian Provincial Health Bureau

44 Why did not this happen earlier? The politics explain this. The first phase of China’s national healthcare reform programme was rolled out in 2009 and ended in 2011. The Chinese top leaders promised the citizens to bring remarkable progress in addressing the problems of kanbing gui and kanbing nan. Despite the fact that almost all related bureaucracies were mobilised to overcome the notorious “policy deadlock”, the MOH still played a crucial role. More important, among all five key components of the reform programme, the MOH is responsible for leading the public hospital reform, the most critical part of the programme. It is widely known that the key driver behind the rising costs in China has been its public hospitals, and thus whether the central government’s commitment could be delivered depended ultimately on the progress of the public hospital reform. Unfortunately, the evidence from the grassroots showed an even faster growth in healthcare costs. For numerous Chinese people, the principal — or perhaps the only — criterion for judging the result of this healthcare reform was whether their medical bills could be reduced. However, the statistical evidence and continuous complaints from the ground both showed poor results. Hence, the MOH was very eager to see a marked cost-containment effect before the first phase of the reform ended in 2011. In the plan for the public hospital reform in 2011 drafted by the MOH, it was even stressed that some reform measures with “immediate effects” (jianxiao kuai) should be developed and executed soon, vividly mirroring the MOH’s anxiety.

has been greatly empowered to reassert this legitimacy and has transcended the conventional boundary of “technical supervision” to manage a much broader spectrum of hospital activities. By prescribing clearly-defined indicators with targets, it employs mainly traditional command-and-control mechanisms supplemented with minor monetary incentives to influence hospital behaviours. This is underpinned by the government’s ownership of public hospitals.

Apart from casting new light on health policy reform and public administration, Fujian’s case can also be viewed in terms of health economics literature, namely cost containment strategies. By and large, demand-side controls and supply-side controls constitute the menu. The control knobs of these two lines of strategy are predominantly consumer cost-sharing and provider payment methods. Both are widely used in the real world. However, there has been a rising recognition of the superiority of supply-side controls. Ellis and McGuire contend that demand-side controls generally force the patients to bear a greater risk of illness and monetary loss. This results from the fundamental limitation of demand-side cost-sharing. As it is one instrument aimed at two conflicting goals (risk pooling and appropriate incentives to consume), it can achieve only a second-best allocation. Supply-side cost-sharing is arguably superior because it directly alters the incentives facing providers, and more importantly, changing supply-side cost-sharing does not impose financial risks on patients. While several local experiments with alternative payment methods have shown impressive results in containing healthcare expenditures, this article suggests that, without touching the economic levers, cost containment could also be achieved by concerted administrative actions. Behind this reform lies the empowered health bureaucracy, the reassertion of its statutory authority and the realignment of government tools at its disposal. This case demonstrates that with a conducive political environment and with support, the Chinese local health bureaucracy is able to undertake meaningful policy interventions to tackle difficult policy problems, based on existing authority, power and instruments.

Last, yet importantly, given the political leaders’ real policy goal and the inherent limitations of the design, this type of administrative campaign is of a transitional and temporary nature. While it is able to bring about decreased medical costs, if the ultimate goal of reform is to achieve sustainable cost containment and improve the performance of the healthcare system, policy-makers should use the upcoming nationwide campaign to re-establish the collapsed accountability mechanism.

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